

**PM FORM 7.4.1
INCIDENT/ACCIDENT/DEATH REPORT FORM**

INSTRUCTIONS:

1. Complete **ALL** sections of this form. Information provided must be either typed or printed.
2. Incidents, accidents and deaths occurring in facilities licensed by the ADHS Office of Behavioral Health Licensure (OBHL) must be verbally reported to OBHL (602-364-2595) within 24 hours and reported in writing to OBHL (FAX 602-364-4801) within 5 working days.
3. Incidents, accidents and deaths, including those occurring during a T/RBHA or provider sponsored prevention activity affecting non-enrolled persons must be reported in writing to the TRBHA within 48 hours, or two business days.
4. **You may fax the form to:**
Magellan at 1-888-290-1282 or 1-888-290-1285, Attention: QI Dept.
Or, you may mail the form to:
Magellan Health Services of Arizona
Attention: QI Dept.
P.O. Box 68110
Phoenix, AZ 85082-8110
Or, you may email the form to: QIRisk@MagellanHealth.com

Behavioral Health Facility Name:	Behavioral Health License#:	Subclass:	Tracking ID#:
Behavioral Health Facility Address & Phone #:			
TYPE OF REPORT: Check all that apply			
<input type="checkbox"/> Death (All Must Be Reported) <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide (victim) <input type="checkbox"/> Accident <input type="checkbox"/> Natural <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown			
THE FOLLOWING ARE REPORTED ONLY FOR THOSE INCIDENTS OCCURRING ON PREMISES OR DURING A LICENSEE SPONSORED ACTIVITY OFF PREMISES, INCLUDING A LICENSED SPONSORED PREVENTION ACTIVITY, IN WHICH CASE REPORTING IS REQUIRED FOR NON-ENROLLED PERSONS: <input type="checkbox"/> Medication Error(s) (requiring medical services) <input type="checkbox"/> Adverse Reaction to Medication (requiring medical services) <input type="checkbox"/> Physical Abuse/Allegation <input type="checkbox"/> Sexual Abuse/Allegation <input type="checkbox"/> Suicide Attempt (requiring medical services) <input type="checkbox"/> Self-Inflicted Injury (requiring medical services) <input type="checkbox"/> Physical Injury (requiring medical services) <input type="checkbox"/> Food Poisoning (requiring medical services) <input type="checkbox"/> Physical injury that occurred as the result of a personal or mechanical restraint.	THE FOLLOWING VIOLATIONS, RESULTING FROM PROVIDER STAFF ACTION OR OMISSION, ARE REPORTED REGARDLESS IF THEY OCCURRED IN AN OBHL LICENSED FACILITY, OR NOT. <input type="checkbox"/> Member Rights Violation/Allegation (specify below): <input type="checkbox"/> Discrimination <input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Exploitation <input type="checkbox"/> Coercion <input type="checkbox"/> Manipulation <input type="checkbox"/> Retaliation for submitting complaint to authorities <input type="checkbox"/> Threat of discharge/transfer for punishment <input type="checkbox"/> Treatment involving denial of food <input type="checkbox"/> Treatment involving denial of opportunity to sleep <input type="checkbox"/> Treatment involving denial of opportunity to use toilet <input type="checkbox"/> Use of restraint or seclusion as retaliation APS OR CPS Referral was made: <input type="checkbox"/> Abuse or neglect reported to Adult Protective Services <input type="checkbox"/> Abuse of neglect reported to Child Protective Services		
<input type="checkbox"/> Unauthorized Absence from Residential Agency/ Inpatient Treatment Program/Level IV Transitional Agency who are under the age of 18; or Adult Therapeutic Foster Home. <input type="checkbox"/> Suspected or alleged criminal activity either occurring on the premises or off the premises during a licensee-sponsored activity.	<input type="checkbox"/> Discovery that a client, staff member, or employee has a communicable disease (listed in R9-6-202) <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Additional reports required by the T/RBHA or Arizona State Hospital:		

Name or Enrolled/Non-enrolled Person: _____

ENROLLED MEMBER OR NON-ENROLLED BEHAVIORAL HEALTH RECIPIENT INVOLVED IN INCIDENT:

Name: _____ CIS ID#: _____
Address: _____ Phone: _____
Age: _____ DOB: _____ Gender: Female
Male

Check All That Apply: Title XIX Title XXI Non Title XIX/XXI Non-enrolled
SMI SMI/Special Assist. SA/GMH Child

Current Diagnosis: Axis I _____ Axis II _____ Axis III _____

Date of Last Visit to Psychiatrist: _____ Psychiatrist Name: _____

Date of Last Visit to Nurse: _____ Date of Last Visit to Clinical Liaison: _____

INCIDENT DETAILS:

Date & Time of Incident: _____
Address & Location: _____
Provider Name: _____
Provider Address: _____
Program Admission Date: _____

Name of Clinical Liaison & Phone Number: _____

INDIVIDUALS WHO OBSERVED INCIDENT (including staff and witnesses):

Name: _____ Relationship to enrolled/non-enrolled person: _____
Address: _____ Phone#: _____

Name: _____ Relationship to enrolled/non-enrolled person: _____
Address: _____ Phone#: _____

Name: _____ Relationship to enrolled/non-enrolled person: _____
Address: _____ Phone #: _____

Name or Enrolled/Non-enrolled Person: _____

DESCRIPTION OF INCIDENT

Describe the events leading up to and including the incident:

Describe the person's physical and behavioral health condition before the incident:

Describe the person's physical and behavioral health condition after the incident:

Document any actions taken and/or recommendations for action to prevent a similar incident from occurring in the future:

Preparer's Name & Title:

Phone#:

Preparer's Signature:

Date Signed:

COMPLETE THIS SECTION FOR ALL INCIDENTS/ACCIDENTS REQUIRING MEDICAL SERVICES

Who provided immediate attention: _____

Who provided medical services: _____

Date and time of medical services: _____

Emergency Room (ER) services:

If YES, name of ER: _____

YES

NO

Name of ER: _____

Hospital admission:

If YES, name of hospital and date of admission: _____

YES

NO

Name of hospital: _____

Attending physician: _____

Results of medical services:

Medications: _____

Date of admission: _____

Name or Enrolled/Non-enrolled Person: _____

CLINICAL DIRECTOR'S OR DESIGNEE'S REVIEW OF INCIDENT: Review all relevant information and documentation in the member's record. Ascertain objectively what occurred and document any actions you have taken and/or recommendations that you have made. **NOTE:** This section **MUST** be completed and signed in order for the incident to be processed.

CLINICAL DIRECTOR OR DESIGNEE'S NAME & CREDENTIAL & TITLE:

PHONE#:

CLINICAL DIRECTOR OR DESIGNEE'S SIGNATURE

DATE SIGNED: